MARION GENERAL HOSPITAL, INC.
FINANCIAL ASSISTANCE POLICY (FAP) APPLICATION
ONLINE – www.marionhealth.com
Business Office – 765/660-6100
Physicians' Billing – 765/660-7600

PATIENT AND FAMILY INFORMATION

PATIENT NAME:______________________________SS#:____________________Birth Date:_____

SPOUSE/GUARANTOR NAME:_________________SS#:___________________Birth Date:______

ADDRESS:____

PHONE NUMBER:____

NUMBER OF DEPENDENTS __________

LIST DEPENDENTS_________________________SS#_________________Birth Date_____

LIST DEPENDENTS_________________________SS#_________________Birth Date_____

LIST DEPENDENTS_________________________SS#_________________Birth Date_____

LIST DEPENDENTS_________________________SS#_________________Birth Date_____

LIST DEPENDENTS_________________________SS#_________________Birth Date_____

NOTE: NUMBER OF DEPENDENTS IN HOUSEHOLD INCLUDING PATIENT AND THE FOLLOWING INDIVIDUALS WHO LIVE WITH THE PATIENT. PATIENT'S SPOUSE, PATIENT'S BIOLOGICAL, ADOPTIVE OR STEP CHILDREN UNDER THE AGE OF 18.

A. **EMPLOYMENT INFORMATION**

GROSS MONTHLY INCOME BEORE TAXES _______________

NOTE: Documentation is required to support income submitted: Last year's income tax return or W-2 forms, verification of Social Security and/or pension benefits, 3 most recent paystubs if there has been a change in income from last year or other proof of annual income.

B. **POTENTIAL SOURCES OF INCOME**: (Please list all potential sources of income)

a. Federal Taxable Wages (from your job) $__________________
b. Tips $__________________
c. Self-Employment income $__________________
d. Unemployment compensation $__________________
e. Social Security $__________________
f. Social Security Disability Income (SSDI) $__________________
g. Retirement or pension income $__________________
h. Capital gains $__________________
i. Investment Income $__________________
j. Rental and royalty income $__________________
k. Excluded (untaxed) foreign income $__________________

l. CHECKING $____________________SAVINGS $________________CD $_______________
m. ESTIMATED HOME VALUE_________________

VERIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATIONTHE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

I understand that the statements I have made on this form are subject to investigation and verification. I understand that I will be asked to provide proof of the information which I have given on this form, and I agree to help the Hospital obtain the necessary verifications. I hereby authorize the release of wage information, financial information from banks and other financial institutions and from the Department of Health and Human Services to the Hospital.

Patient's Signature: ____Date:_____________

Spouse/Guarantor's Signature:____Date:_____________

Please do not hesitate to contact us if you have any questions. This application is good for 6 months at which time a new application should be submitted.